SOCIAL SESSIONS APPLICATION

GENERAL INFORMATION
Where did you hear about KidsTLC Autism Services? ☐ School ☐ KidsTLC Website ☐ Friend ☐ Other:
Additional Documentation Requested: ☐ Recent photo of your child ☐ Most recent annual IEP, and all subsequent addenda

Enrollment Days:

Please put an X in the box you would like your child to attend. You may enroll for more than one week. Enrollment confirmation is dependent on same-age group availability and making sure that the camp can meet your child's needs.

Check Here	Age Group	Day of the Week	Time	Conflict Notes/Comments
	Elementary Group (6-11)	Mon/Wed.	4:00 to 6:00 pm	
	Elementary Group (6-11)	Tues/Thur.	4:00 to 6:00 pm	
	Middle School Group (12-14)	Mon/Wed.	4:15 to 6:15 pm	
	Middle School Group (12-14)	Tues/Thur.	4:15 to 6:15 pm	
	High School Group (15-18)	Mon/Wed.	3:30 to 5:30 pm	
	High School Group (15-18)	Tues/Thur.	3:30 to 5:30 pm	

DEMOGRAPHICS			
Client Full Name:			Today's Date:
DOB:	Age:	Gender:	Check One: ☐ Hispanic ☐ Non-Hispanic
Mother or Legal Guardian Information			
Full Name:			Relationship to Child:
Address:			Occupation:
Name of Employer:			
City:			Business Phone:
State:			E-mail:
Home Phone:			Cell Phone:
Father or Legal Guardian Information			
Full Name:			Relationship to Child:
Address:			Occupation:
Name of Employer:			
City:			Business Phone:

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State:	E-mail:
Home Phone:	Cell Phone:

Client's Siblings		
Name:	Age:	Gender:
Name:	Age:	Gender:

Annual Household Income

☐ Below $30,000 ☐ $30,00-$50,000 ☐ $50,000-$75,000 ☐ $75,000-$100,000 ☐ $100,000+ ☐ $200,000+

Child/Young Adult: Educational Placement

Name of School:	Years attended:	Hours:

School Services: ☐ SPED (partial day) ☐ SPED (full day) ☐ Regular Ed/Inclusion ☐ Private School

☐ 1:1 School Aide ☐ SLP ☐ OT ☐ APE ☐ Counseling

Does your child exhibit problem behaviors such as refusal to follow directions or aggression while in school? Y N

Does your child exhibit attention issues in school requiring 1:1 support or frequent redirections? Y N

Address:	City:	State:	Zip:

Phone:	Can Contact: ☐ Yes ☐ No
Contact Person:	Signed Consent for Release of Information with School in File: ☐ Yes ☐ No

MEDICAL INFORMATION

Diagnosis:	Age of Diagnosis:	Physician/Group:

Primary Physician: Phone Number:

Are there any medical conditions that need to be considered when delivering treatment (e.g., seizure disorder, diabetes, heart condition, hydrocephalus treated by shunt, irritable bowel syndrome, physical disability)?

☐ Yes ☐ No If yes, please provide specific details (use the reverse side if needed).

Does your child have any allergies? ☐ Yes ☐ No

If yes, to what?

Does your child have any dietary restrictions? ☐ Yes ☐ No

If yes, what restrictions?

Is your child on medication? ☐ Yes ☐ No

If yes, list medication, administration times, usage below:

Type of Medication	Dosage	Administration Times	Used for

Additional Information:

Additional medications can be attached on a separate sheet of paper and stapled to this document

DEVELOPMENTAL HISTORY

Has/Did your child reach the following developmental milestones accordingly?

Gross Motor: ☐ Yes ☐ No If no when:
Fine Motor: ☐ Yes ☐ No If no when:
Language: ☐ Yes ☐ No If no when:
Self-Help: ☐ Yes ☐ No If no when:
Academic: ☐ Yes ☐ No If no when:

Once your child started to talk did he/she continue to add new words? ☐ Yes ☐ No
Did your child ever seem to lose skills that he/she had previously mastered? ☐ Yes ☐ No
Has your child ever had any seizure activity? ☐ Yes ☐ No
What types of foods does your child typically eat? Are there any foods your child will not eat?

Does your child have any difficulty falling asleep or staying asleep? Does s/he nap?

Are there any legal or custody issues that we need to be aware of or that may impact services?

☐ Yes ☐ No If yes, please explain:

Is there any other background information about the client/your family that would be useful for our team members to know?

HISTORY OF TREATMENT

Has your child in the past or are they currently receiving Applied Behavioral Analysis Services?

☐ Yes ☐ No If yes, please provide a brief description include with whom and frequency of services:

Has your child in the past or are they currently receiving Speech and Language Services?

☐ Yes ☐ No If yes, please provide a brief description include with whom and frequency of services:

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Has your child in the past or are they currently receiving Occupational Therapy Services?

☐ Yes ☐ No If yes, please provide a brief description include with whom and frequency of services:

FAMILY HISTORY & LEGAL ISSUES

Is there a history of mental health conditions in the family? (Please answer if known and you are comfortable providing this information.)

☐ Yes ☐ No If yes, please explain:

What is the primary language for the client/family? _____

Does your family/the client speak any other language at home?

☐ Yes ☐ No If yes, please provide specifics:

Are there any legal or custody issues that we need to be aware of or that may impact services?

☐ Yes ☐ No If yes, please explain:

Is there any other background information about the client/your family that would be useful for our team members to know?

Parent Concerns and Goals

Please describe the greatest social, communication and behavioral concerns that you have at this time along with any goals you have for your child while receiving services through KidsTLC.

Communication:

Community:

Emotional:

Behavior:

AUTHORIZATION AND AGREEMENT

"I authorize investigation of all statements contained in this Application for Admission to KidsTLC, Inc. In the event of admission, I understand that false or misleading information, given in the application of my child, or in any interviews, may result in termination of admission."

_____ _____

Parent/Legal Guardian DATE Parent/Legal Guardian DATE